Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-09-B574-01
DIPTI PATEL, DC 6660 AIRLINE DR. HOUSTON, TX. 77076	
Respondent Name and Box #:	
ZURICH AMERICAN INS. CO. REP. BOX # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "Our facility has billed these services accordingly…."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $79.85
3. CMS 1500
4. EOBs
5. Pre-authorization letter
6. Medical record

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The carrier believes that it has reimbursed the requestor at a rate consistent with the applicable fee guidelines…."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
10-7-08	97110 97140	A & F A & F	1, 2, 3, & 4 1, 2, 3, & 4	$38.19 $35.37
Total Due:				$73.56

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled *Medical Fee Guideline for Professional Services* effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied/reduced by the Respondent with reason codes "A" (pre-authorization/certification not obtained) and "F" (workers compensation state fee schedule adjustment).
2. A review of the pre-authorization letter submitted identifies that 10 sessions/visits of codes 97110, 97112, and 97140 were authorized to be completed by 10-6-08. It is noted that the DOS in dispute is 10-7-08, which falls outside the authorized time frame; however, due to the Governor's disaster proclamation of Hurricane Ike affected counties, this DOS/time frame is tolled and is eligible for review; Commissioner's Bulletin #B-0059-08 and #B-0059-08A.
3. The pre-authorization letter; number 2643788, did not stipulate/address the number of units to be performed; therefore, it is not appropriate to deny additional units during the bill audit process as "not authorized". The requested additional unit of each of the disputed codes is recommended for payment in accordance with Rule 134.203 (b) and (c) (1).
   - 97110: $52.83 divided by 38.087 =1.3870 x $27.53 =$38.19
   - 97140: $52.83 divided by 38.087 =1.3870 x $25.50 =$35.37
4. Per review of Box 32 on the CMS-1500, zip code 77076 is located in Harris County. The maximum reimbursement amount, under Rule 134.203 (b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.203
Texas Government Code, Chapter 2001, Subchapter G
Commissioner's Bulletin #B-0059-08 and #B-0059-08A

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $73.56 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	10-20-09 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.